

BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

ROY R. GETTEL, M.D.

Holder of License No. 11015
For the Practice of Allopathic Medicine
In the State of Arizona.

Board Case No. MD-02-0675A

**FINDINGS OF FACT,
CONCLUSIONS OF LAW
AND ORDER**

(Decree of Censure)

The Arizona Medical Board ("Board") considered this matter at its public meeting on December 10, 2003. Roy R. Gettel, M.D., ("Respondent") appeared before the Board without legal counsel for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). After due consideration of the facts and law applicable to this matter, the Board voted to issue the following findings of fact, conclusions of law and order.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 11015 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-02-0675A after receiving notification of a malpractice settlement involving Respondent's care and treatment of a 47 year-old male patient ("KT").

4. On October 24, 1997 KT was examined in the emergency department at Northwest Medical Center ("Northwest") after suffering an injury to his right ankle in a conveyor belt. The Northwest physician recorded that the right foot was slightly mottled, but had brisk capillary refill. Also noted was a slight valgus angulation of the foot with 1+

1 pulses. The Northwest physician reduced the valgus angulation after obtaining an x-ray
2 that showed a comminuted angulated fracture of the distal fibula and tibia. After
3 Northwest physician performed the reduction KT had better capillary refill, less mottling
4 and 2+ distal pulses. Northwest physician splinted KT's leg and contacted Respondent.

5 5. Respondent dictated a history and physical for KT on October 24, 1997
6 noting that KT's right leg was encased in a spiral splint with "his toes intact." Respondent
7 performed surgery on KT later the same day. The records indicate that Respondent
8 initially exposed the fibula through a longitudinal incision and fixed it with a tubular plate,
9 four proximal screws and two distal screws. There is no indication that Respondent
10 performed decompression of any of the compartments of the leg, other than that which
11 would occur with routine exposure of the fibula. Respondent utilized an external fixator to
12 reduce and hold the tibia. When the tourniquet was released Respondent dictated that
13 the circulation was slow to return to the foot. Records from the recovery room indicate
14 that Respondent obtained "Doppler pulses and the dorsalis pedis and . . . maintained
15 pretty good circulation to the toes. No sensation returned with the 'dermimorph' on hand,
16 but it looked like some minimal pulsation was getting to the toes despite the coldness and
17 relative whiteness. That was not unexpected due to the crush injury that [KT] sustained."

18 6. Respondent was asked if there was a pre-operative examination of the
19 extremity in terms of establishing neurovascular status. Respondent stated that at the
20 point of his pre-operative examination KT's ankle was returned to position and in a splint,
21 which he did not remove, so he did no examination other than the tip of the toes.
22 Respondent stated that KT could move his toes and had capillary refill.

23 7. Respondent stated that he had no reason to question Northwest physician's
24 determination of 2+ pulses. Respondent was then asked to explain what occurred from
25 the time Northwest physician reduced the fracture in the emergency department to the

1 time after surgery that would cause 2+ palpable pulses to come down to only
2 Dopplerable pulses as noted by Respondent in the operating room. Respondent stated
3 that the only answer he has for that is that the venous injury to the leg and the soft tissue
4 injury of the leg were so substantial that there became a blockade to the arterial inflow
5 and the pulses diminished on that basis.

6 8. Respondent was asked that, if his explanation was correct, how should that
7 be handled. Respondent stated that he did exactly what was appropriate by using a
8 minimally invasive external fixator, driving two wires across the tibia instead of drilling
9 them so he did not wrap up any artery or nerve or tendon and then fixing it in the frame
10 and getting the best alignment he could with the best length he could and then fixing the
11 fibula, at that point draining the four compartments to drain as much of the venous side of
12 the blood as possible.

13 9. Respondent was asked if it was his normal practice, as he indicated in
14 correspondence to the Board, to decompress the compartments when he puts on a
15 lateral side plate. Respondent stated that once you open a fracture, that is the fibula, that
16 by taking out a small segment of the fibula, all four compartments are released.
17 Respondent stated that with a comminuted fracture of the fibula, opening the skin and
18 putting a side plate on and then letting the compartments drain through that incision he
19 believes is the release of the four compartments.

20 10. Respondent was asked if in looking at the operative report it would appear
21 that after surgery he had concerns about KT's vascular status. Respondent noted that he
22 believed the injury was primarily venous and not arterial. Respondent was asked to
23 address the arterial inflow in light of the nurses' assessment in the recovery room that KT
24 had capillary refill greater than 3 seconds, the foot was white, only a Dopplerable pulse
25 could be obtained and the foot was cold to the touch – all of which indicate that the foot

1 may not have arterial inflow. Respondent stated that there was not as much arterial
2 inflow as he would have liked to see, but with the venous damage and the tourniquet
3 used to put on the external fixator and the plate on the fibula, sometimes there is a
4 relatively slow return for the first hour or so in the recovery room. Respondent was asked
5 if three hours after the surgery he would have expected to see better arterial inflow.
6 Respondent said he would have. Respondent was asked to address the nurses' notes
7 that indicate he did not return to the bedside until 13:25 the next day. Respondent stated
8 that he saw KT about one and one-half hours after surgery and then not until the next
9 day.

10 11. Respondent was asked what action should be taken when a patient has an
11 exam that reveals a white foot that seems to be dyvascular. Respondent stated that if
12 the whiteness were based on the venous outflow an effort would need to be made to
13 elevate the foot, which was done, put the patient on vasodilators, and then get some sort
14 of sympathetic blockade. Respondent stated that he was sure KT was put on
15 vasodilators.

16 12. Respondent was asked how problems with arterial flow should be
17 managed. Respondent stated that, if the problem appeared to be serious, an arterial or
18 vascular consult should be obtained. Respondent was asked if the data suggested that
19 KT had an arterial insult, specifically the nurses' notes that document every hour there
20 were no pulses and that the color of the foot had not changed. Respondent stated that
21 he did not get any calls from the recovery room all night so he would not have known of
22 the nurses' notes. Respondent was directed to his first note after seeing KT the day after
23 surgery. The note indicates "Insensible ankle distal right foot. Mottled but okay range of
24 motion. Feeling may be lost secondary due morph . . . Lasts up to 24 hours. Pulses not
25 palpable TMAX, 100. Vital signs okay. Up 8, okay. Family active plantar massage.

1 Encouraged patient to go to PT." Respondent was asked if this note indicates that he
2 himself documented that KT did not have pulses nearly 18 hours after the surgery, which
3 corresponds to the nurses' notes because none of the notes for KT's entire hospital stay
4 say that postoperatively they were able to get anything more than a Dopplerable pulse
5 and most of them were absent. Specifically, Respondent was asked how this was only a
6 venous injury. Respondent stated that the leg was grossly swollen, the foot was mottled
7 and sensation was decreased, a lot of which goes along with arterial loss, pain, pallor,
8 and paraesthesias. Respondent testified that his thought was to get the foot moving, get
9 some isometric exercises going to try and get the venous flow better. Respondent stated
10 that he thought if he could get the venous return better the arterial inflow would improve.

11 13. Respondent was asked that when the venous return did not get better at an
12 early point would not it have been prudent to get a vascular consult or to do an
13 arteriogram to find out exactly what was going on with the arterial inflow. Respondent
14 stated that retrospectively he could not disagree. Respondent was asked if it was
15 advisable to place a tourniquet on a patient he knew postoperatively may have vascular
16 compromise. Respondent stated that he could argue that either way, but in retrospect, it
17 probably would have been better not to use a tourniquet on KT. Respondent was asked
18 what his thinking was behind the continuous epidurals. Respondent stated that they
19 were for a sympathetic blockade as well as pain control, but mostly sympathetic block in
20 order to get better venous return. Respondent was asked what his plan was if the
21 epidurals did not work. Respondent stated that the plan was to get consults.

22 14. Respondent was asked if four days after surgery was a reasonable period
23 of time to obtain consults. Respondent stated that in retrospect it was not a reasonable
24 period of time. Respondent was asked if he ever documented neuromuscular on KT,
25 whether he had any compartment measures or post-operative orders telling the nurses to

1 watch for neuromuscular changes. Respondent stated that he never documented there
2 was no compartment syndrome, but the checks to KT's toes, the motion of his toes from
3 the long tendons, both in flexion and extension was just there a little bit for the first two or
4 three days, but not big. Respondent also noted that it did not hurt KT to dorsiflex the
5 toes. Respondent was asked if he documented that it did not hurt KT to dorsiflex the
6 toes. Respondent stated that he commented on the CMS checks, the circulatory, motor
7 and sensory examinations of KT's foot, but did not specifically note that it did not hurt KT
8 to dorsiflex the toes.

9 15. Respondent summarized his testimony by stating that he was dealing with a
10 crushed leg and that he got KT to the operating room within 6 hours. Respondent stated
11 that he thought he decompressed the compartments, but the Board raised an interesting
12 thought that perhaps he did not decompress the deep posterior compartment.
13 Respondent testified that he thought he had excellent position of the foot and he had
14 Doppler pulses in the recovery room. Respondent stated that the next day KT just went
15 downhill and as the arteriogram shows, he just did not have good arterial flow to the foot.
16 Respondent stated that KT was in sort of a hopeless situation from the beginning with the
17 type of crush injury he had and Respondent thought he did the least invasive procedure
18 he could while still decompressing as best he could.

19 5. The standard of care required Respondent to recognize that there was a
20 vascular injury and that urgent attention to that injury in the form of a vascular
21 consultation was necessary.

22 15. Respondent fell below the standard of care because he failed to recognize
23 the vascular injury and consequently did not secure an urgent vascular consultation.

24 16. KT was harmed because he ultimately underwent a below the knee
25 amputation of his leg.

17. A mitigating factor is that KT presented with a difficult injury and there is a possibility that the outcome may not have changed even if some of the interventions took place.

18. Respondent's history with the Board is an aggravating factor in that he has previously been before the Board on a number of occasions and some of those cases relate, at least in part, to examinations that may not have been completed pre-operatively, which is one of the issues in this case.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances above in constitutes unprofessional conduct pursuant to A.R.S. § § 32-1401(26¹)(q) (“[a]ny conduct or practice that is or might be harmful or dangerous to the patient or the public;”) 32-1401(26)(II) (“[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.”)

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED that Respondent is issued a Decree of Censure for failing to timely secure an urgent vascular consultation for the clinical signs and symptoms of circulatory compromise.

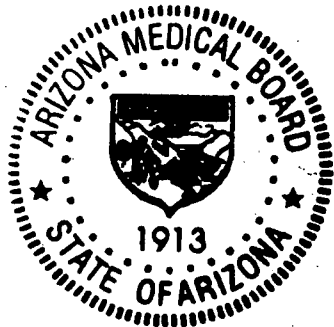
¹ Formerly A.R.S. § 32-1401(24). Renumbered effective September 18, 2003.

1 **RIGHT TO PETITION FOR REHEARING OR REVIEW**

2 Respondent is hereby notified that he has the right to petition for a rehearing or
3 review. Pursuant to A.R.S. § 41-1092.09, as amended, the petition for rehearing or
4 review must be filed with the Board's Executive Director within thirty (30) days after
5 service of this Order and pursuant to A.A.C. R4-16-102, it must set forth legally sufficient
6 reasons for granting a rehearing or review. Service of this order is effective five (5) days
7 after date of mailing. If a motion for rehearing or review is not filed, the Board's Order
8 becomes effective thirty-five (35) days after it is mailed to Respondent.

9 Respondent is further notified that the filing of a motion for rehearing or review is
10 required to preserve any rights of appeal to the Superior Court.

11 DATED this 17th day of February, 2004.



THE ARIZONA MEDICAL BOARD

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By Amende Richt
BARRY A. CASSIDY, Ph.D., PA-C
Executive Director

ORIGINAL of the foregoing filed this
17th day of February, 2004 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing
mailed by U.S. Certified Mail this
17th day of February, 2004, to:

Roy R. Gettel, M.D.
Address of Record

for M'Gra